

**CINCINNATI PAIN MANAGEMENT CONSULTANTS, LTD.
REGISTRATION SHEET**

Name		Date	
Address		Phone ()	
City	State	Zip	
SS #	DOB	Sex	Marital Status
Emergency Contact		Phone ()	
Employer Name		Phone ()	
Referring Physician		Phone ()	
Primary Physician		Phone ()	
Pharmacy Name		Phone ()	

RESPONSIBLE PARTY INFORMATION

Name of Responsible Person		
Address		Phone ()
City	State	Zip

INSURANCE INFORMATION

Primary Insurance
Secondary Insurance

Patients or Authorized Persons Signature:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including medicare, private insurance, and any other health plan to Cincinnati Pain Management Consultants, LTD.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assigned all information necessary to secure payment.

SIGNED _____ **DATE** _____

**CINCINNATI PAIN MANAGEMENT CONSULTANTS, LTD.
PAIN ASSESSMENT FORM**

Name _____ DOB _____

Referring Physician _____ Primary Physician _____

Primary Pain Complaint (Reason for referral)

History of Pain Complaint (Onset? Progression? Changes? Treatments? Patterns?)

Describe Pain(s)

Quality: Sharp Dull Aching Cramping Burning Stabbing Shooting
(Please circle) Gnawing Tender Spasms Numb Throbbing Stinging Electrical

Other: _____

Intensity: (scale 0 to 10: 0 = no pain and 10 = worst pain of your life)

Usual @Rest @ Work Worst Best

With Medication Without Medication

Patterns: Constant Cyclical Intermittent Variable Unpredictable
(Please circle)

Activity Dependent Progressive through day Fades through day

Responses: Typical: Activity & work increase / rest & hest decrease
Atypical: Activity & work decrease / rest or inactivity increase
Other: Explain how the following items affect your pain? (I = Increase D=Decrease)

Heat Cold Weather changes Stress Sitting Standing

Sleep Changes in position Walking Driving Kneeling

Lying down Lifting Bending Twisting Rest

Associations: What other symptoms are consistently associated with the pain?

Physicians consulted for present pain complaint

Name	Date	Result of treatment	Report?	
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N

Diagnostic test performed (check if done and give dates - include reports if available)

- MRI
- CT Scan
- X-Rays
- EMG

Treatments used to treat your pain complaint

- Medications (Include names, dose, benefits or side effects)
- Injections: Epidurals, triggerpoints, facet blocks, nerve blocks, etc. (Report type, dates performed & benefits received)
- Surgeries (Include surgeon's names, surgery type and effect on pain)
- Self directed treatments (Home exercie, herbal medicines, etc.)

Is this pain related to a work injury or care accident?

(Describe the work or car accident and if legal action has been pursued)

Pain effect on your life

(Describe how your life has changed because of the pain)

Interference of hobbies, pleasurable activities or social events?

Changes in mood, coping ability or perceived quality of life?

Financial change due to the pain: income or job changes?

Sleep Patterns

Total Hours _____ Awakening Y N How often? _____

Difficulty initiating sleep Y N Difficulty maintaining Y N

Specific activity limitations from the pain

(Circle the activities below that are affected and estimate how much you can perform each activity at your usual, present pain level)

Walk	Hours	Stand	Hours
Sit	Hours	Drive	Hours
Push	Lbs	Pull	Lbs
Carry	Lbs	Lift	Lbs
Climb	Hours	Crawl	Hours

Previous Pain Problems

Have you had any prior, persistent pain problems that have required extended treatment? Please check and describe below:

- Chronic headaches _____

- Persistent neck pain _____

- Chronic low back pain _____

- Pelvic pain _____

- Abdominal pain _____

- Arm or leg pain _____

- RSD _____

- Nerve pain _____

Past Medical History

What medical illnesses are you being treated for or have been treated for in the past? Please check, circle and describe below:

- Heart Disease: Murmurs/valve disease MVP Heart surgery Angina Hypertension
Heart attack/MI Heart failure/CHF Irregular heartbeat/arrhythmia
- Lung Disease: Asthma COPD Emphysema Bronchitis TB Sarcoidosis Cancer Surgery
- Intestinal Disease: Gastritis Ulcers GERD Esophagitis Abdominal Surgery Cancer Pophyria
Colitis Crohns Hepatitis Live failure Cirrhosis Pancreatitis Bowel Obstruction
- Kidney Disease: Kidney failure Dialysis Stones Nephritis Prostate disease BPH
Incontinence Interstitial cystitis
- Nerve Disease: Stroke/CVA Seizures MS Migraines Cancer Neuropathy Dementia
Brain injury Familial tremors
- Hormone Diseases: Thyroiditis Graves Goiter Pheochromocytoma Menopause Medications

Bone Disease: Osteoarthritis rheumatoid arthritis Join deformities Osteoporosis/Thin bones
SLE/Lupus Pagets

Blood Disease: Anemia Polycythemia Leukemia Hemophilia/Bleeding tendencies
Lymphoma Von Willebrands Thrombocytopenia

Muscle Disease: Fibromyalgia/Fibromyositis Muscular dystrophy Polymyositis Myopathy

Past Surgical History (Circle, give date and explain, if necessary, in the space provided)

Eye Ear Nose Throat Oral/Dental

Brain Nerves Lumbar Spine Cervical Spine

Heart Lungs Blood Vessels

Stomach Intestines Gallbladder Colon Hernia

Uterus Ovaries Genitalia Bladder Rectum

Wrist/Hand Shoulder/Elbow Hip/Knee/Feet Arm/Leg

Social History

Marital status: Single Married Divorced Widowed
Children at home? Y N How many? _____
Hobbies and interests _____

Dietary Habits:
Caffeine? Cups/servings per day: _____
Alcohol? Drinks per day: _____
Tobacco? Packs per day: _____
Restrictions? _____

Health Habits:
Exercise? Times per week: _____ Type: _____
Stress management? Technique: _____
Religious activity? Describe: _____

Education:
(Circle highest grade completed) Primary School High School College Graduate School
Occupation: _____

Presently employed?
Employer/Occupation _____
Last day worked _____
Not presently employed?
Reason: Retired Disabled Laid off
Disability Type: TTD PPD PTD Medical-SSI
Last day worked _____ % disability rating _____
Legal Counsel for disability: _____
Previous occupation: _____
Previous employer: _____

Family History

(Please circle and provide medical history)

Mother: Alive & well Living with medical illness Deceased

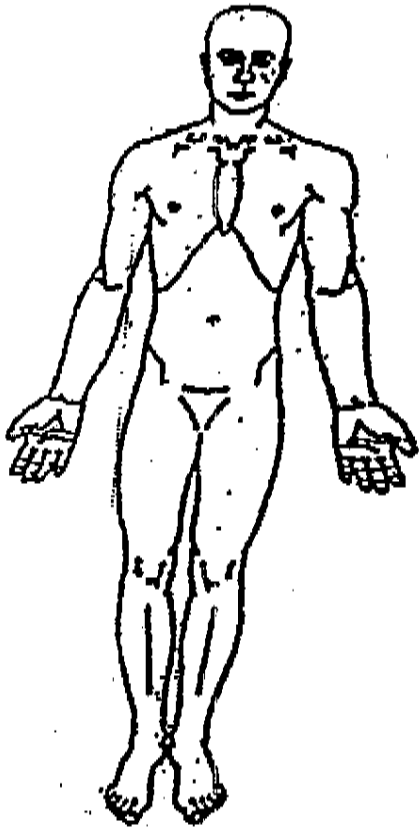
Father: Alive & well Living with medical illness Deceased

Brothers: Alive & well Living with medical illness Deceased

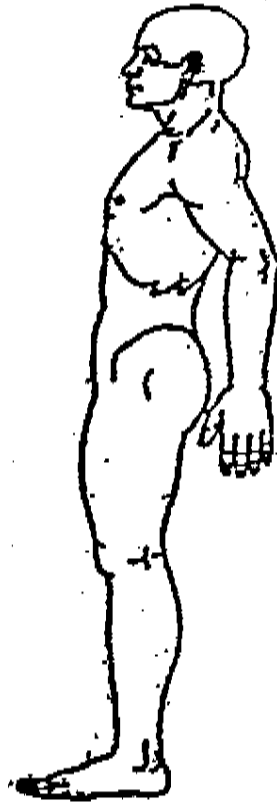
Sisters: Alive & well Living with medical illness Deceased

Do pain problems exist in any other family members? Y N (If yes, please explain)

INDICATE LOCATION OF PAIN



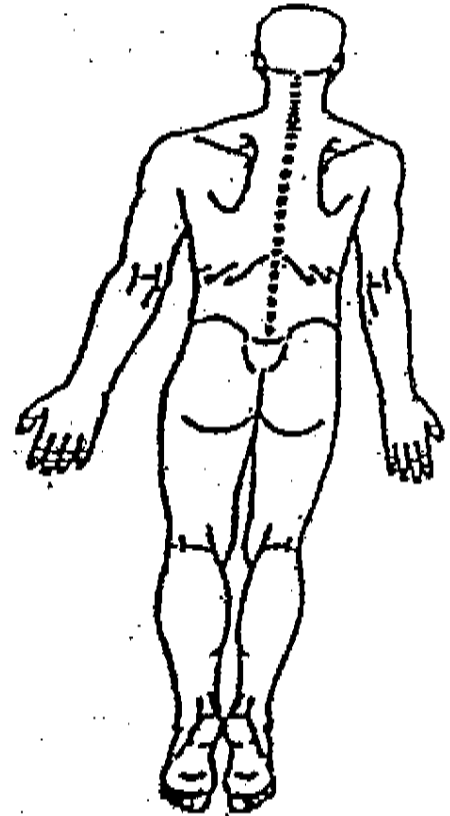
RL



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